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Narratives of experience: Senior registered nurses working with new graduate nurses in the intensive care unit

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Chapter 5: Discussion

This current inquiry employed NI methodology when exploring five SRNs' experiences working with NGNs in the ICU. Braun and Clarke's (2006) thematic analysis was used to seek resonant major and minor threads across the narrative accounts to explain the SRNs' experiences. Two major threads were found, the first being 'Reverberations', containing five minor threads, 'We Carry Them', 'It's Dangerous', 'Patrolling Like Surf Lifesavers', 'Enjoyable Moments' and 'Survival Mode', and the second being 'Caring', containing three minor threads, 'I've Been There', 'They Must Ask Questions' and 'Not In My Backyard'. In this chapter, a discussion of the threads is presented sequentially and relevant literature reported. Concluding remarks include recommendations for practice.

The major thread 'Reverberations' represented the prolonged and continuing effect SRNs experience when working with NGNs in the ICU. The ICU clinical environment was described by SRNs as being busy and stressful, with high-acuity patients' illness trajectories requiring the integration of constantly evolving advanced medical technology. The SRNs' descriptions of working in the ICU as being demanding, emotional and stressful mirrored those by other authors who describe a highly stressful and pressured environment (Gohery & Meaney, 2013; Khan, Jackson, Stayt, & Walthall, 2018; Moss et al., 2016). The ICU clinical environment is compounded by multiple nursing role assignments (Matlakala, Bezuidenhout, & Botha, 2014), complex technology (Wung et al., 2018) and challenging nursing routines associated with direct patient care such as: managing end-of-life care issues, prolonging life by use of mechanical support, performing cardiopulmonary resuscitation, participating in post-mortem care and supporting families (Mealer et al., 2012). Patients admitted to the ICU require the support of many life-sustaining medical devices and interventions; they are the most critically ill and complex patients in a hospital setting (Kruer, Jarrell, & Latif, 2014). Additionally, nursing management of ICU patients requires extensive knowledge and experience to safely and efficiently use continually evolving technologically advanced medical devices (Wung et al., 2018). New Graduate Nurses enter this multifaceted environment as part of their TPP, causing the 'Reverberations' experienced by the SRNs who work alongside them.

Participant SRNs perceived that NGNs were inadequately prepared for clinical practice in ICUs. In the minor thread 'It's Dangerous' SRNs raised concerns regarding NGNs' clinical practice, including their slow work pace, individual task focus and an inability to recognise and respond to patient deterioration. This finding is consistent with those of researchers who reported SRNs considered NGNs to be inadequately prepared for the demanding pace of acute clinical environments (Ballem & MacIntosh, 2014; Baumberger-Henry, 2012). Ballem and MacIntosh (2014) recruited participants from five clinical environments, including critical care [ICU] nursing units, and Baumberger-Henry (2012) included SRN participants from emergency and critical care units [ICU]. In the study by Baumberger-Henry's (2012) it was determined that NGNs did not possess the required nursing skills to safely and independently work in critical care areas, such as the ICU and the ED.

The major thread 'Reverberations' and the minor thread 'It's Dangerous' highlighted the participant SRNs' perception that NGNs were not adequately prepared for the ICU clinical environment. The SRNs in this current inquiry considered NGNs to be task focused and dependent on SRN guidance, support and education to safely care for critically ill patients. Globally, the shortage of ICU RNs has impelled ICUs to employ NGNs and junior nursing staff, necessitating more supervision and support from SRNs (Department of Health, 2004). A North American report found 23.3 % of NGNs were working in critical care areas 6.5 months' [average] post registration (National Council of State Boards of Nursing, 2018). Critical care areas in this report were defined as ICU, CCU, step-down units, paediatric or neonatal ICUs, EDs and post-anaesthesia recovery units (National Council of State Boards of Nursing, 2018). The findings of this study align with those of another (O'Kane, 2012), with participant SRNs suggesting that NGNs should gain student experience in ICUs. However, it is recognised in these studies, that student placement in ICU may not always be possible.

As discussed in the minor thread, 'It's Dangerous', SRNs perceived the NGNs as not having the advanced clinical skills required in ICU to be able to recognise and, rapidly intervene and care for a deteriorating patient. However, it has been asserted that the aim of universities is to prepare nursing students for generalist nursing clinical practice and not speciality practice, such as the ICU (Swinny & Brady, 2010). Placing NGNs in ICUs has implications for nursing education and emphasises the need to expose nursing students to critical care settings as part of their curriculum and clinical placements.

Providing pre-registration ICU education helps prepare NGNs to care for critically ill patients (Department of Health, 2004). Since significant numbers of critically unwell patients are clinically managed outside dedicated ICU facilities (Lewis, 2011), graduating nurses should possess the skills and knowledge to assess and manage critically ill patients, regardless of their location within the hospital.

Studies exploring nursing students' experience of ICU clinical placements have been presented in the literature (Doucette, Brandys, Canapi, & Davis, 2011; Vatansever, Nursel, & Neriman, 2016). Vatansever et al. (2016) studied the experience of 18 first-year nursing students in one Turkish university hospital ICU. The ICU was reported to be a stressful and overwhelming place to learn and practice nursing skills. This finding was supported by Doucette et al. (2011); however, the authors reported participant students developed coping mechanisms to overcome psychological and physical challenges of ICU nursing. When considering the stressful nature of the environment and the student's limited autonomy in the ICU compared with that in clinical wards, Vatansever et al. (2016) recommended the ICU clinical environment may be better suited to nursing students who were close to graduation.

Despite the reported benefits of providing pre-registration ICU nursing education, such as learning the skills to assess and manage critically ill patients (Department of Health, 2004), and enhancing recruitment to critical care areas such as ICU (Swinny & Brady, 2010), there are difficulties when supporting nursing students in ICUs. Providing clinical placements for increasing student numbers placed increased pressure on RNs to provide good quality supervision in clinical environments (Mould, White, & Gallagher, 2011). Concerns raised by SRNs associated with supporting nursing students in ICUs include balancing time for patient care with teaching and inadequate staffing levels (Carlson et al., 2010). Henderson et al. (2010) highlighted that SRNs have a dual role: They ensure the delivery of high-quality care for patients and concurrently supervise nursing students. The double functions are demanding and stressful because of the pressure of clinical commitments, such as simultaneously providing support for NGNs and lack of time for educational opportunities, and reflects the findings of this study from the themes 'We Carry Them' and 'Survival Mode'.

The SRN participants in this current inquiry raised concerns that first rotation NGNs entered ICU without the required skills to safely care for critically unwell patients. The

participants suggested nursing skills and knowledge learned during undergraduate study did not prepare the NGNs for the reality of working in ICUs. This finding was reported in the minor thread 'Not In My Backyard' of the major thread 'Caring'. This finding is at odds with that of Williams and Palmer, (2014) who report ICU placements during undergraduate study provide nursing students the skills to assess and manage critically ill patients. Gallagher, Rice, Tierney, Page and McKinney (2011) stated findings from an evaluation of a two-day critical care course for nursing students. The authors reported that 89.6 % of student participants (n = 182) perceived their level of confidence increased when caring for critically ill patients and 88.2% of participants believed their knowledge and skills had improved. However, this study reported limitations and did not assess students' actual ability. Therefore, the nursing students' perceptions of increased skill as it relates to demonstrated competence could not be established. This reflects the findings of this inquiry, where the SRNs perceived NGNs as not possessing required skills, however actual competence was not measured. Further research is indicated, measuring whether clinical skills and knowledge taught in undergraduate education are associated with demonstrated ICU clinical competence and preparedness for practice.

The minor thread 'It's Dangerous' in the major thread 'Reverberations' described the SRNs' perception of NGNs' possession of basic nursing skills and knowledge in an area that required competence in advanced time management, patient assessment and critical thinking skills, and the ability to instigate timely and vital therapeutic interventions. The perceived gap between the NGNs' skills and knowledge and the requirements of critically ill ICU patients concerned the SRNs. In the current inquiry, SRNs reported feeling pressured and stressed in their accountability for ensuring ICU patients' high-quality, safe and timely care. The participants felt a personal responsibility to ensure NGNs did not make errors in patient care since the former were acutely aware that such mistakes could have negative outcomes for patients. Ballem and MacIntosh (2014) explored the perceptions of SRNs working with NGNs in different work environments, including an ICU. They reported a similar finding, with SRNs feeling the constant burden of being responsible for, and watchful over, NGNs.

During periods of increased activity, SRNs reported a reduced ability to provide patient and NGN surveillance, perceiving the reduced surveillance as a potential patient safety issue. This finding was described in the third minor thread 'Patrolling Like Surf Lifesavers' within the major thread 'Reverberations'. A seminal US report articulated the

importance of RNs in patient safety (Committee on the Work Environment for Nurses and Safety Board on Health Care Services, 2004). Published by the US Agency for Health-Care Research and Quality, it identified multiple threats to patient safety, including inadequate training and insufficient supervision. Significantly the report identified that RNs play an essential role in patient safety, providing the most direct care, observing for clinical changes and initiating rescue interventions (Twigg, Duffield, & Evans, 2013). The importance of RNs to patient safety is additionally emphasised by data from the Joint Commission on the Accreditation of Health Organisations database on sentinel events. Sentinel events defined as ‘any unanticipated event in a health care setting resulting in death or serious physical or psychological injury to a person or persons, not related to the natural course of the patient’s illness’ (Hoonakker et al., 2011). Over a seven-year period, 1995–2002, 19% of total errors reported identified RN staffing levels as one of the four causative factors. Other factors were inadequate staff orientation and training, competency assessment and a breakdown in communication (Committee on the Work Environment for Nurses and Safety Board on Health Care Services, 2004).

An important finding described in the minor thread ‘Patrolling Like Surf Lifesavers’ within the major thread ‘Reverberations’, is the SRNs in this current inquiry recognised their significant role in the surveillance, intervention and rescue of ICU patients from harm. However, participant SRNs reported they often did not have the nursing resources to adequately provide surveillance to NGNs in the ICU. Twigg et al. (2013) supported this finding, stating patient safety, ‘can only be realised if there are sufficient nurses to provide appropriate care’ (p. 544). Additionally, Peet, Theobald, & Douglas, (2019) assert that the capacity for nursing surveillance may be unravelled by the context in which the RNs practice; recognising the political and social tensions inherent in everyday nursing practice ‘have a profound impact on patient care’ (p. 2931).

Senior Registered Nurses in this current inquiry reported that NGNs’ lack of experience in providing nursing care in the ICU created additional workload challenges for the SRNs. The minor thread ‘We Carry Them’ in the major thread ‘Reverberations’ highlighted factors such as staffing resources, time constraints, reduced break time and concurrent roles that contributed to SRNs’ workload concerns. The SRNs felt an obligation to provide safe and high-quality patient care in addition to supporting NGNs. Participant SRNs reported they delayed and went without meal breaks to ensure adequate patient surveillance; they answered numerous requests for guidance and information by NGNs

and worked with them to ensure NGNs completed all their nursing tasks promptly. When patients deteriorated, SRNs rapidly intervened, often taking full responsibility for the NGNs' patients in addition to their own responsibilities. These interactions increased the workload of SRNs, who reported feeling tired when required to continually support NGNs.

The NGNs impact on SRNs' workload, as discussed in the threads, 'Survival Mode' and 'We Carry Them' and concerns regarding NGNs preparedness to work in a Level 6 ICU as represented in 'Not in My Backyard', may be exacerbated by organisational factors inherent in *sociality*, specific to this *place*. Although this inquiry was not specifically examining either the organisational or ICU context features that might impact the SRNs' experience, the context in which this inquiry was located did not align with standard six of the ten standards inherent to the ACCCN workforce standards for intensive care nursing (Chamberlain, et, al., 2018). The ICU in this inquiry does not roster a pre-determined number of ACCESS RNs to optimise patient safety or maximise ICU bed utility, which may contribute to the SRNs' perceived workplace stress and, specifically their perceived increased workload when working with NGNs (Chamberlain, et, al., 2018).

In response to requests from the Australian intensive care nursing profession, the Australian College of Critical Care Nurses (ACCCN) sought to develop a robust evidence based position statement on the ICU nursing workforce. The aim was to 'develop standards that defined a safe and sustainable intensive care nursing workforce to ensure the best outcomes for critically ill patients' (Chamberlain, et, al., 2018. p. 293). Post a systematic review of the literature and further evidence review, analysis and grading of included studies, all ten draft standards were deemed to be supported by a body of evidence of at or above grade C. The draft of the standards was reviewed by professionals and consumers, including relevant advisory panels. The guidelines were appraised using the AGREE II instrument by eight nursing clinicians, who were not involved in the standard's development from the Intensive Care Services Network, Agency for Clinical Innovation, New South Wales, Australia (Chamberlain, et, al., 2018).

It has been reported that increases in patient acuity and health care costs associated with providing care for sicker patients place substantial financial pressure on acute care hospitals. Health care providers are often asked to provide the same level of care with fewer resources (Duchscher & Cowin, 2006). New nurses are entering professional practice in clinical areas affected by unparalleled workload expectations and high levels of stress (Duchscher & Cowin, 2006). Senior Registered Nurses who work in these areas are exhausted, which ultimately affects their capacity to mentor and act as role models to NGNs (Ballem & MacIntosh, 2014). Senior Registered Nurses in this current inquiry recognised preceptoring was essential to the support and development of NGNs; however, they also perceived preceptoring to increase their workload. This finding is similar to the findings of Shermont and Krepcio (2006), who sought to evaluate the turnover rates in three inpatient surgical units at a US children's hospital. The authors acknowledged the burden placed on the role when preceptors were required to assume TL responsibilities or take a patient allocation in addition to their preceptor responsibilities.

High workload is an identified major concern in health care, particularly in ICUs, (Hoonakker et al., 2011) and a significant job stressor reported by ICU SRNs (Kiekkas et al., 2008). The SRNs in this inquiry described increased workloads when working with NGNs in the ICU. The thread 'We Carry Them' within the overarching thread 'Reverberations', supports the findings of Ballem and MacIntosh (2014), whose theme, 'Carrying the Load' reports SRNs were stressed, overwhelmed and exhausted when carrying a greater workload while working alongside NGNs.

High workloads can have negative consequences for ICU nurses, including burnout syndrome (BOS), which in turn, is associated with decreased well-being and quality of patient care, and increased fiscal costs associated with turnover rates and absenteeism (Embriaco et al., 2007). Intensive Care Unit patient care is affected by high nurse workload, resulting in poor patient outcomes, complications and increased mortality (Gurses, Carayon, & Wall, 2009). These outcomes may be related to the lack of time to perform vital patient care tasks. Given the evidence of high workloads on ICU nurses and patients, it has been considered important to examine workload dimensions, such as time pressure and physical, mental and emotional workloads (Carayon & Alvarado, 2007), in addition to examining the methods employed to measure workload (Hoonakker et al., 2011).

Workload can be difficult to define and conceptualise particularly when considering global differences in the staffing, management and financing of ICUs. Workload has been defined as the ‘momentary relative capacity to respond’ (Lysaght, Hill, Dick, Plamondon, & Linton, 1989, p. 204) and ‘a multidimensional and complex construct, that is affected by external task demands, environmental, organizational and psychological factors, and perceptive and cognitive abilities’ (Weinger, Reddy, & Slagle, 2004, p. 1419). Developments in treatments available for critical illness have altered the types of patients being admitted to ICUs with more elderly patients, those with pre-existing chronic disease and greater severity of illness being admitted (Carmona-Monge, Rodríguez, Herranz, Gómez, & Marín-Morales, 2013). The nursing care required by these ICU patients, and consequently the ICU nurses’ workload burden, is directly influenced by the use of increasing numbers of therapeutic interventions (Carmona-Monge et al., 2013). Additionally, RNs with limited independent nursing experience post registration are commencing their professional careers in ICU (Bortolotto, et. al., 2015). These NGNs require significant support from SRNs to ensure they are adequately supported; increasing the workload of the SRNs (Ballem, 2014). Measuring ICU nursing workload may be equally difficult considering the patient and operator approaches available (Hoonakker et al., 2011). Patient-based workload measures only consider characteristics such as the number of patients, nurse-to-patient ratio, patient acuity and time. Conversely, operator-based workload measures consider nurse characteristics, including their interaction with the working environment (Carmona-Monge et al., 2013).

For decades, attempts have been made to demonstrate ICU cost–benefit ratios via a variety of tools designed to measure severity of patient illness in addition to the true cost of ICU nursing workload. Miranda, Nap, de Rijk, Schaufeli and Iapichino (2003) developed the Nursing Activities Score (NAS), validated in a study of 99 ICUs across 15 countries. This tool measured additional nursing activities, such as care of relatives and administrative tasks, and found these to account for 60% of average nursing time. The Nursing Manpower Use (NEMS) tool was developed from a more complicated tool, the Therapeutic Intervention Scoring System (TISS; Reiss Miranda, Moreno, & Iapichino, 1997). Carmona-Monge et al. (2013) sought to determine the workload relationship between the NAS and the NEMS in addition to their ability to measure the staffing needs in the ICU and whether it was appropriate to meet the needs of the patients (Carmona-Monge et al., 2013). The authors determined a strong association between measurements

despite the NEMS being based on the critically ill patient's therapeutic interventions and the NAS attributing greater specific weighting to standard independent activities of ICU nursing care. However, it was noted that the main difference between the tools was in the determination of staffing levels. Estimated nursing staffing needs through the NAS were significantly higher than through the NEMS, since the former assesses nursing activities extending beyond those associated with patient severity or therapeutic interventions. Carmona-Monge et al. (2013) remarked that in both cases, regardless of the tool used, estimated staffing needs established through the tools were higher than currently provided in the ICU in which their study was situated.

Hoonakker et al. (2011) sought to apply the NASA task-load index (TLX) tool, developed to measure aviation workload (Hart, 2006), to health care with the aim of examining ICU nurses' workload. Data were collected from 17 ICUs in seven US hospitals. Hoonakker et al. (2011) concluded the NASA-TLX is a valid and reliable tool to measure nurse workload in ICUs. The authors established the tool was easy to administer and complete, allowing researchers to measure different dimensions of ICU nursing workload. The dimensions included mental, physical and temporal demands. This study was unique because it studied both patient and operator dimensions of workload. Workload tools, such as those described, could be used to measure SRN's workload. Initiatives to reduce the risk of BOS, address perceived staffing concerns and trial different NGNs' orientation, induction and supernumerary models, could employ the NEMS, TISS or NASA-TLX as a pre-and post-intervention measure of SRNs' workload when working with NGNs in the ICU. This proposition is discussed in more detail in the recommendations chapter.

The degree to which SRNs in the thread 'Survival Mode' within the major thread 'Reverberations' reported feeling worried, stressed, irritable, pressured and tired when working alongside NGNs in the ICU is of concern since these symptoms may be indicative of chronic stress. Senior Registered Nurses in this inquiry described negative emotions, perceiving they were unable to provide an acceptable level of patient care. Huntington et al. (2011) in their study of RNs in Australia, New Zealand and the United Kingdom (n = 7604) working predominantly in acute hospital facilities (n = 3975) reported similar findings and suggested their findings may be consistent with the definition of burnout. The term burnout is defined as a psychological syndrome that occurs in response to chronic stressors and exhibits as 'emotional exhaustion,

depersonalization and reduced personal accomplishment' (Maslach, 2003, p. 12). Burnout is not uncommon in ICU RNs with Merlani et al. (2011) reporting 28% of RNs (n = 2415) in their study of 2 996 ICU caregivers in 74 Swiss ICUs, exhibited a high degree of burnout. Consequences of burnout to nursing staffs' health manifest clinically and include insomnia, irritability, tiredness, emotional instability, eating problems and headaches (Poncet et al., 2007). Senior Registered Nurses in this current inquiry reported similar symptoms, such as irritability, tiredness and emotional instability. The SRNs also reported a potential new finding—they drank alcohol to wind down after a shift and as a coping mechanism.

Burn Out Syndrome is the result of chronic stress, yet Merlani et al. (2011) reported high stress levels did not always correlate with high burnout. Merlani et al. (2011) hypothesised being burned out may reduce stress resistance thus contributing a 'vicious cycle wherein the role of each factor might be confounding' (p. 1144). It has been suggested that burnout may not be gender specific (Merlani et al., 2011) but linked to the individual health care worker's psychological and empathic traits and whether individuals have self-caring support systems that mitigate the detrimental effects of stress (Azoulay & Herridge, 2011). Although SRNs in this current study reported findings of feeling pressured, stressed and overwhelmed, they also described positive moments and recognised beneficial aspects of working with NGNs in the ICU. This inquiry's finding is supported by that of Azoulay and Herridge (2011) who reported SRNs' individual traits may provide a degree of mitigation for both stress and burnout.

The findings of this current inquiry report participant SRNs [with an average 13 years of experience at this inquiry site], despite feeling overwhelmed, stressed and pressured, have an enduring capacity to work in the ICU environment. Burgess et al. (2010) support this finding, reporting that although the ICU workplace is an area susceptible to staff turnover and nursing shortages some RNs thrive in the high-stress ICU environment, maintaining their interest and desire to work despite the inherent stressors. The ability to thrive in a stressful environment could be explained by individual SRN's possession of inherent resiliency, resiliency being a 'multidimensional characteristic that allows an individual to thrive when faced with complexity and high rates of change' (Moss et al., 2016, p. 373). The current inquiry's findings are also supported by Mealer et al. (2012), who report the presence of resilience in a subsection of ICU nurses was associated with a significantly reduced rate of BOS and symptoms of depression and anxiety. Resilience has been

reported as playing a role in establishing healthier psychological profiles of ICU nurses, acting as a safeguard against burnout (Charney, 2004; Chlan, 2013; Mealer et al., 2012). Resilience can be learned with psychologists identifying factors that promote resilience, such as family relationships, external support systems and individual temperaments (Mealer et al., 2012). Personal qualities, such as the ability to engage the support of others, faith, optimism, altruism, the belief that stress can be strengthening, and striving towards personal goals, are also associated with resilience (Charney, 2004; Hoge, Austin, & Pollack, 2007; Luthar, Cicchetti, & Becker, 2000; Mealer et al., 2012). The personal qualities and factors associated with resilience reflect this current inquiry's findings as described in the major thread 'Caring'. The SRNs reported: engaging the support of the ICU nursing team to overcome stressful situations, providing support to NGNs despite the associated increase in workload and moderating their communication and interactions with NGNs when under pressure, and through reflection on their own ICU experiences, showed empathy to NGNs working in the ICU.

As presented in the final thread 'Enjoyable Moments' within the overarching thread 'Reverberations', SRNs in this current inquiry described positive experiences related to working with NGNs in the ICU. Although literature describing the experiences of SRNs working with NGNs in the ICU is limited, the available literature describes positive aspects of working with NGNs. Ballem and MacIntosh's (2014) study reported SRNs were motivated by the presence of NGNs to refresh their nursing skills and knowledge, thus keeping their personal nursing practice current. Further, SRNs in Baumberger-Henry's (2012) study recognised that NGNs completing orientation in critical care areas such as ICUs had positive benefits on individual SRN's workload and general staffing levels. The current study presents new findings, with participant SRNs articulating feeling proud of NGNs when they progressed clinically and professionally in the ICU. The SRNs communicated their sense of satisfaction when NGNs voiced their gratitude and thanked the SRNs for their support while on ICU placement.

Despite SRNs in this current inquiry reporting NGNs' nursing skills were at a basic entry level in an area that required advanced nursing skills, and despite the impact this had on their workloads, SRNs were supportive of, and exhibited care towards, NGNs, as described in the overarching thread 'Caring'. This finding of the concept of caring was supported by studies (Ballem & MacIntosh, 2014; O'Kane, 2012) that reported SRNs eased the transition of NGNs into professional practice and were cognisant of their role

obligations to be supportive of NGNs. However, SRNs in this inquiry explicitly commented that NGNs were considered a part of the team, and despite the associated increased workloads and levels of stress and pressure associated with working with NGNs, actively cared for and supported the NGNs. The SRN participants recognised that initial experiences in nursing could have a profound effect on NGNs' future careers and therefore tried to ensure that NGNs' ICU experiences were positive.

However, these findings are at odds with studies (Baumberger-Henry, 2012; Duchscher, 2009; Johnstone et al., 2008; Laschinger et al., 2010; Parker et al., 2014) that described the unsupportive behaviours SRNs exhibited towards NGNs. The discrepancy in findings might be explained by differences in workplace culture, leadership qualities and available resources between the sites in which the studies were situated. Additionally, the capacity of individual RNs, nursing units and organisations to engage with NGNs, support their ongoing education and provide resources to gradually assume full RN responsibilities and expectations may affect SRNs' behaviours towards NGNs. Regardless of the rationale for the behaviour, Baumberger-Henry (2012) emphasised that SRNs who ignore or remain silent when witnessing SRNs' nonconstructive interactions with NGNs legitimise this unsupportive behaviour.

This current inquiry's findings discussed in the thread 'I've Been There' within the overarching thread, 'Caring' aligns with that of another study (Ballem & MacIntosh, 2014) describing the reflective practices of SRNs towards NGNs. These findings highlight that SRNs support NGNs as they transition into professional practice. The SRNs in both studies personally reflected on their own experiences as new RNs working in an acute care hospital. Their reflection enhanced their empathy towards NGNs and their willingness to support NGNs' workload in addition to their own and to provide emotional support. The SRNs' reflections on their previous disparate early experiences in the ICU motivated them to ensure the NGNs' ICU experience was positive. Evidence that SRNs continued to reflect on their practice was apparent in the findings and has been supported by Hodges, Troyan & Keeley's (2010) study, which suggests that RNs should continue to reflect and critically appraise their practice because reflection leads to an increased capacity to support colleagues to remain in the adverse, complex and unpredictable health care system.

The participant SRNs, as discussed in the thread 'They Must Ask Questions', within the major thread 'Caring', highlighted the importance of NGNs asking questions and seeking advice from more senior colleagues when they recognised limitations in their knowledge and skills. The SRNs perceived that when NGNs did not ask questions or seek advice, there was an increased potential risk of patient errors. This finding was supported by Baumberger-Henry's (2012) study seeking to explore RNs' perceptions of NGNs working in an emergency or ICU area. The author commented that 'Not asking means that the possibility of causing an error is high' (p. 301). The SRNs in the current inquiry believed that NGNs might conceal their level of knowledge and inexperience and at times were reluctant to seek advice. The SRN participants were concerned about this behaviour because the time-constrained environment of this inquiry's context meant that if NGNs did not ask questions or were not transparent about their level of knowledge, SRNs would not be able to amend their workload to provide the necessary NGN support and education. This perception regarding NGNs affected the SRNs, particularly if they were in the TL role, because the role requirement obliged them to ensure overall patient safety and staff support.

The Senior Registered Nurses postulated NGNs' embarrassment, fear and presence of patients' families underpinned their reluctance to seek SRN advice and ask questions. This finding is supported by studies that report on the presence of NGNs in the ICU from either the NGN or SRN perspective. Saghafi et al. (2012) reported NGNs attempted to hide their ICU nursing inexperience from patients and families, believing their inexperience might influence the level of patient trust in their capacity to implement patient care. Baumberger-Henry's (2012) study suggested NGNs' desire to be autonomous prevented them from asking SRNs questions. These findings are concerning, because SRNs recognise their obligation to teach NGNs but are constrained if NGNs do not ask questions, attempt to obscure their level of knowledge or are not aware of their knowledge gaps. Workload demands can limit the SRNs' capacity to undertake vigilant surveillance of NGNs and ICU patients. Senior Registered Nurses rely on NGNs to raise concerns regarding their patients' condition so that they can provide support, advice and clinical interventions in a timely manner, thus ensuring patients receive best possible nursing care. However, if NGNs do not ask questions or vocalise their concerns, both NGNs and ICU patients receive less than optimal support.

The thread 'Not In My Backyard' in the overarching thread, 'Caring' examined the SRNs' belief that the NGNs' lack of ward experience and knowledge of how the wider hospital worked in conjunction with the ICU restricted their ability to work in the ICU environment. The ability to clinically assess patients without the use of monitors or advanced technological equipment was perceived by SRNs as being a skill more readily gained in hospital wards. Since SRNs were quick to take over the care of the deteriorating patient, something that may not readily occur in a hospital ward, participant SRNs suggested that NGNs may have fewer opportunities in ICUs, unlike in lesser acuity clinical areas, to gain skills such as accountability and responsibility. This finding was mirrored in O'Kane's (2012) study where SRNs' perceived the lack of NGNs' ward experience 'was a potential hindrance to nurses' development in ICU' (p. 49). Correspondingly, in O'Kane's (2012) study, SRNs identified that experience in a clinical area without monitoring and technology gave NGNs an opportunity to gain basic assessment skills. Further, ward experience was thought to encourage NGN skills such as, 'accountability, responsibility, and the ability to prioritize' (p. 49).

Within the overarching thread, 'Reverberations', SRNs in the current inquiry, described the hectic, stressful, dangerous nature of the high-acuity ICU environment in the thread 'It's Dangerous' and the pressure and added workload required to support NGNs while sustaining high-quality, safe patient care in the threads 'Survival Mode' and 'We Carry Them'. The participant SRNs perceived the NGNs' nursing skills as being inadequate to meet the needs of critically unwell ICU patients. The SRNs recommended that because of the nursing skill and experience mismatch between NGNs and ICU patients' requirements, first rotation NGNs should not be placed in ICU on a TPP program. However, SRNs' views differed in this regard. Some suggested that NGNs should not work in ICUs until they had practiced for a year in a clinical ward area whereas others proposed that NGNs be allocated a rotation in ICUs after a six-month placement in a clinical ward area, provided the SRNs were given adequate resources to sufficiently support the NGNs and their allocated patients. Similar concerns were raised by SRNs in Baumberger-Henry's (2012) study regarding the placement of NGNs in critical care areas with SRNs stating problems with, 'time management and basic skills, fear, and inability to think critically' (p. 301). A participant in Baumberger-Henry's (2012) study stated, 'I don't believe graduate nurses should be in the emergency department or intensive care

unit. It's this constant stop go, stop go, and a lot of people don't have the basic down at that point' (p. 301).

Nursing staff shortages and high levels of intention to leave rates are a global concern, especially in highly specialised environments such as ICUs. There has been a significant change in nursing culture in recent times with ICUs now offering orientation and transition programs to NGNs (Bortolotto, 2015; Friedman et al., 2011), often with the intended aim of ameliorating staffing shortages. Programs to successfully familiarise NGNs with the ICU and increase staffing levels have been shown to be cost effective, despite the financial resources required to run the program (Bortolotto, 2015). The SRNs in the current inquiry supported the development of NGNs and recognised their crucial role in supporting NGNs' transition into professional practice. However, they also reported in the minor thread 'We Carry Them' within the major thread, 'Reverberations', difficulty in consistently supporting NGNs because of skill mix and workload concerns. This finding is concerning since Hussein et al. (2018) reported that NGNs' intention to stay is directly related to their not being placed in clinical situations beyond their individual capability. Additionally, NGNs' intention to remain in critical care areas produced two significant and independent predictors: high satisfaction with unit orientation score and high satisfaction with clinical supervision. Previous research also confirms that NGNs who feel better supported are more likely to be satisfied and indicate an intention to stay in their current critical care area (Parker et al., 2014).

However, these studies did not evaluate the perceptions and experiences of SRNs who play a vital role in orientating, inducting and clinically supporting the NGNs. If a perceived effective critical care unit orientation and clinical supervision increases NGNs' intention to remain in critical care areas (e.g., ICUs), addressing the challenges experienced by SRNs, as reported in the findings of this inquiry, associated with providing support in areas affected by increased admission rates, patient acuity and complexity is warranted (Hussein, et. al., 2018). The SRNs' capacity and willingness to provide clinical supervision to NGNs working in ICUs deserves further investigation.

The ideal length of ICU orientation programs has not been established in the literature, although many authors describe programs lasting 12 to 26 weeks (Bortolotto, 2015; Friedman et al., 2011; Proulx & Bourcier, 2008). Suggested supernumerary periods for NGNs differ in the literature. O'Kane (2012) recommended NGNs should receive an

eight-week supernumerary period, supported by two preceptors irrespective of experience. Atherton and Alliston (2011) reported a 10-week supernumerary period for NGNs entering the department of critical care medicine on a nursing entry to practice program. Commenting on the Australian experience, Missen, McKenna and Beauchamp (2016) reported that NGNs in one regional ICU were supernumerary for the entire three-month rotation. In comparison, these programs differ significantly from this inquiry's *place*. In this context, the organisation offers an orientation program comprising of a three-day induction with CNEs, then one-week supernumerary for first rotation NGNs and three days for second rotation NGNs. The NGNs are subsequently enrolled in an ICU specific, three-day didactic 'Introduction to ICU' course.

The workload and pressures experienced by the SRNs, as described in the minor threads, 'We Carry Them' and 'Survival Mode', relate specifically to working with the NGNs in ICU, however there may be organisation wide factors impacting these findings that should be considered. There is current Australian research examining the NGNs' perceptions of practice environments and clinical supervision and, how these variables influenced NGNs' intention to stay in non-critical and critical care areas post their TPP program (Hussein et al., 2019). However, there is a dearth of literature exploring the organisational and contextual factors that influence ICU SRNs' capacity to support NGNs and, their own workload during the orientation and supernumerary period. This may be an area suitable for further investigation.

Best nursing practice in ICU endeavours to counteract and reduce the severity of complications associated with critical illness. Senior Registered Nurses working in ICU carefully observe and clinically assess ICU patients and on interpreting all available data instigate timely and appropriate interventions and therapies (Adam, 2017, p. 54). However, NGNs possess basic skills and are reliant on SRNs to provide education, advice, and surveillance when managing high-acuity patients in critical care areas such as ICUs (Baumberger-Henry, 2012). The Dreyfus Model of Skill Acquisition suggests that during the acquisition and development of skills, an individual progresses through five levels of proficiency: novice, advanced beginner, competent, proficient and expert (Benner, 1982). Benner's (1982) study confirmed the model can be applied to nurses when acquiring clinical nursing skills. NGNs are classified as advanced beginners since they experience every clinical situation as a multitude of competing tasks, all of which seem of equal priority (Benner, 1982). Although NGNs are deemed competent by the

higher education institution to be registered by Australian Health Practitioner Regulation Agency, when performing basic nursing skills, they continue to require support and assistance from experienced RNs. Senior Registered Nurses in ICUs play a vital role in the clinical development of NGNs as they transition into professional practice and gain experience.

5.1 Limitations

Limitations of qualitative studies may occur in the lack of congruence between philosophical underpinnings, methodology and methods, potentially limiting the trustworthiness of the research. The visibility of researcher reflexivity throughout this thesis, together with the inclusion of the researcher's Narrative Beginnings Account in the appendices (see Appendix C), demonstrated that congruence was maintained within this Narrative Inquiry.

The limitations of Narrative Inquiry methodology, as used in this inquiry, are those inherent to immersion in the three-dimensional Narrative Inquiry space. Therefore, this inquiry was limited to the stories of experience told by five participants in one specific place. There is no claim to generalisability of findings. As Narrative Inquiries are less concerned with generalisability and more concerned with a deeper understanding of the research puzzle, the presentation of an examination of the SRNs' stories of experience may encourage readers to rethink and reimagine SRNs' practice in the ICU. Thus, contributing to nursing knowledge in this speciality area.

The relationship between inquirer and SRN participants in this current inquiry, despite acknowledging the relational ontology of NI, may be considered a potential limitation. Although my knowledge of the ICU *place* may have encouraged rich and detailed conversations, I was actively aware that my concurrent role as CNE in the context in which this inquiry was situated, may have influenced my interpretations. Although my reflexivity was visible throughout the thesis, my worldview is not dissimilar to that of the SRN participants and my embeddedness in the inquiry context may have unintentionally constrained some active analysis processes. However, I sought to ameliorate this by presenting the participants' complete narrative accounts to allow readers to consider their own interpretations of the SRNs' stories of experience.

Narrative inquiry methodology explicitly acknowledges that there is no final story, or final telling and ‘no one singular story we can tell. We realize that this is not going to be satisfying for those who want to see truth, or accuracy and verifiability of data’ (Clandinin, 2013, p. 205). The stories told by participants were not narratively smoothed and their inherent tensions and contradictions were made apparent.